



March 7, 2017

Submitted via the Federal eRulemaking Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Re: RIN 0938-AT14 Patient Protection and Affordable Care Act; Market Stabilization

To Whom It May Concern:

We are writing on behalf of the HIV Health Care Access Working Group (HCAWG) – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and Hepatitis C-related health care and support services. We appreciate the opportunity to provide comments to the Department of Health and Human Services (HHS) on the proposed rule regarding market stabilization for the individual and small group markets.

We understand that the uncertainty caused by the current health policy debate in Congress may have implications for the stability of the individual health insurance market in many states. We support federal and state efforts to allay uncertainty among both issuers and consumers and to increase robust competition in the Marketplaces for the 2018 plan year. However, we believe that curbing vital consumer protections with regard to affordability and access is not the way to address stability and that many of the proposed changes to individual market regulation, if enacted, will in fact serve to limit enrollment and competition in the individual market and thereby harm consumers who depend on the marketplace for coverage.

To provide meaningful access to care for people living with HIV and others living with chronic conditions and to promote robust enrollment and competition in the individual health insurance market, we urge HHS to consider the recommendations and comments detailed below.

OPEN ENROLLMENT PERIOD LENGTH (45 CFR §155.410(e))

We recognize that eventually moving to an open enrollment period that does not cross two plan years will be administratively simpler and more efficient. However, we are concerned that given the uncertainty and confusion that surrounded the final days of the 2017 open enrollment period as well as the ongoing uncertainty that Congressional health policy debates have caused, the 2018 plan year is too soon to dramatically shorten the open enrollment period and will ultimately prevent robust enrollment and a balanced risk pool.

We urge HHS to maintain the existing open enrollment period, or at least allow open enrollment until December 31, 2017. If HHS decides to move forward with a shortened open enrollment period for the 2018 plan year, we strongly support additional consumer outreach and education activities to ensure that consumers understand the new timeline and the importance of enrolling in coverage. This includes additional resources for Health Insurance Navigators and other assisters and a robust educational campaign to promote enrollment. In the Proposed 2018 Notice of Benefit and Payment Parameters, the Secretary solicited comments on how to use remaining funds in the Pre-Existing Condition Insurance Plan (PCIP) to transition PCIP clients to exchange plans. In the Final Notice of Benefit and Payment Parameters, the Secretary indicated that it would take no action at this time on the proposal. We encourage the Secretary to use remaining PCIP funds to support consumer outreach and education activities that will facilitate greater enrollment, such as Consumer Assistance Programs, particularly if the Secretary finalizes the shortened open enrollment period.

SPECIAL ENROLLMENT PERIODS (45 CFR §155.420)

Special Enrollment Periods (SEPs) have been an important consumer protection to ensure access to health insurance following a significant life event or evidence of extenuating circumstances that prevented enrollment during the open enrollment period. Absent evidence of abuse (which has not been documented or shown), we do not support proposals that seek to limit availability of SEPs.

We urge HHS to maintain current SEP application and verification standards. Creating burdensome documentation requirements before someone may enroll in a plan, particularly absent evidence of consumers abusing SEPs, will only serve as an enrollment barrier for individuals who have in fact had a qualifying life event. We believe that the current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, should be left in place.

The proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to “accept every employer and individual in the State that applies for such coverage.” (42 U.S.C. § 300gg–1) While issuers “may restrict enrollment ... to open or special enrollment periods,” this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary’s authority to “promulgate regulations with respect to enrollment periods” is limited to just that – defining the enrollment periods under which the issuer “must accept every employer and individual in the State that applies for such coverage.”

We oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs; this is particularly true for people living with HIV and hepatitis C for whom appropriate plan choice is critical to affordable health care access. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

CONTINUOUS COVERAGE

As we stated above, we believe that continuous coverage requirements are antithetical to the guaranteed issue consumer protections of the ACA. Imposing waiting periods before effectuating enrollment, pre-existing condition exclusions, and penalties for people who experience a gap in insurance coverage will harm consumers, particularly those who may be living with disabilities or with serious chronic conditions who are more likely to experience changes in employment and life circumstances throughout the year. Additionally, we note that individuals who need care but are denied coverage due to such rules are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on.

GUARANTEED AVAILABILITY (45 CFR §147.104)

The proposed reinterpretation of the guaranteed availability provision is unlawful and outside the Secretary's authority. We encourage the Secretary to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer “must accept every employer and individual in the State that applies for such coverage.” (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and the Secretary does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate

enrollment procedures for enrollees with prior non-payment, and the Secretary must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments. The Secretary should establish procedures, however, for past due premiums to be pro-rated and added to the insurance premiums for the following year (or partial year, in the case of a special enrollment period) for the enrollee. This would allow issuers to recoup past due premiums while respecting the statutory requirement to accept all applicants. Consistent with statute, issuers could not deny or terminate enrollment for failure to pay the pro-rated past due amount if the current premium is paid; the pro-rated repayment option simply facilitates an issuer's collection of debts that could be recouped under other legal remedies.

Pro-rating the past due amount will facilitate beneficiary re-payment and enrollment in the prior issuer's plan, as requiring the full past due amount at enrollment may be financially impossible for many enrollees. We urge the Secretary to develop clear procedures to notify consumers beneficiaries of past due amounts at the time of plan selection, the pro-rated repayment schedule, and an opportunity to contest the past due amount.

Importantly, many consumers only have access to plans from one issuer due to limited Marketplace competition. Under the Secretary's proposal, if these consumers are unable to fully repay past due premiums upon enrollment, they will be completely unable to obtain any coverage. We believe the possibility of such lockouts could have a chilling effect on enrollment by healthier individuals, especially those with limited incomes, because they might worry that if they do not maintain continuous coverage they will never again be able to purchase insurance and access care when they need it. Pro-rated repayment plans will facilitate these consumers' re-entry into the insurance market, supporting Marketplace stability. Without affordable repayment plans, these consumers may postpone enrollment until they are sick, increasing adverse selection. Clear guidelines on pro-rated re-payment plans are necessary to protect consumers and encourage them to re-enter the marketplace, particularly in jurisdictions with only one issuer.

We support the Secretary's proposal to allow issuers to develop a premium payment threshold policy. Issuers could, for example, allow a beneficiary to pay 60 percent of the past due amount in one payment at enrollment and have the balance of the past due amount forgiven rather than participate in an installment re-payment. Issuers should be allowed to experiment with these repayment models so long as they offer an annualized installment option for the full past due amount. The issuer must be required to provide consumers with a clear and consumer-friendly explanation of all repayment options when the issuer enrolls the past-due consumer.

ACTUARIAL VALUE DE MINIMIS VARIATION (45 CFR §156.140)

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces. Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to “account for differences in actuarial estimates.” (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is “to help issuers design new plans for future plan years, thereby promoting competition in the market.” The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation “to account for differences in actuarial estimates.” The proposed expansion exceeds the Secretary’s authority and undermines the plain meaning of the statute.

Contrary to the proposed rule’s assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee’s income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of \$25,000. This individual’s expected contribution towards premiums is 6.8% of income or \$1,700. If the person selects the benchmark plan, his/her net premium will be \$1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial

value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with HIV, hepatitis C, and other chronic conditions who depend on access to plans with a higher actuarial value to defray high cost sharing. Consider three possible silver benchmark plans:¹

Benchmark Plan Costs, 2018						
Actuarial Value	Gross Premium	Deductible	Maximum Out-of-Pocket	Co-Insurance	Advance Premium Tax Credit	Net Enrollee Premium*
70	\$4,138	\$1,600	\$7,200	30%	\$2,438	\$1,700
68	\$4,020	\$2,100	\$7,200	30%	\$2,320	\$1,700
66	\$3,902	\$2,750	\$7,200	30%	\$2,202	\$1,700

** Examples assume consumer enrolls in the benchmark second lowest cost silver level plan; net premium amount would increase if consumer enrolled in a higher AV plan*

While reductions in actuarial value reduce gross premiums, they do not reduce the net enrollee premium when selecting the benchmark plan resulting in less purchasing power for the consumer. Deductible increases allowed by the actuarial value reductions, however, will discourage enrollment, leading to a death spiral.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with “benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.” (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Under the plans above, using the 70 percent actuarial value plan as the benchmark would result in a 15 percent net enrollee premium reduction for enrollment in the 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease will likely

¹ Actuarial values were calculated using the 2018 Actuarial Value Calculator for silver plans. Premiums assume 85 percent of costs are medical and 15 percent are administrative. Advance premium tax credit is based on a \$25,000 income for a single 35 year-old enrollee, resulting in a \$1,700 expected annual contribution from the enrollee and a \$2,438 tax credit on average nationwide. This example assumes enrollment in the benchmark second lowest-cost silver level plan. The applicable income percentage and gross premium for the 70 percent actuarial value plan were calculated using the Kaiser Family Foundation’s 2017 Health Insurance Marketplace Calculator.

spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan.

Impact of Requiring 70 Percent Actuarial Value (AV) Benchmark Plan					
Actuarial Value	Gross Premium	Advance Premium Tax Credit (70 AV benchmark)	Net Enrollee Premium (\$)	Net Enrollee Premium Reduction (% compared to benchmark contribution of \$1,700)	Increased Deductible (compared to \$1,600 under 70 AV benchmark)
68	\$4,020	\$2,438	\$1,582	7.0%	\$500
66	\$3,902	\$2,438	\$1,464	13.9%	\$1,150

While we do not support expanding the de minimis actuarial value threshold to -4/+2 percent, if the Secretary finalizes this proposal, calculating the advance premium tax credit from plans with a true 70 percent actuarial value will reduce net enrollee premiums and encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

The Secretary must require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. The Secretary is given authority, however, to modify the out-of-pocket reduction only if it would “result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan” above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that the Secretary establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. The Secretary, then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We support the February 24, 2012 Actuarial Value and Cost-Sharing Reductions Bulletin’s explanation for not establishing cost-sharing reduction plans with a 70 percent actuarial value for these enrollees, but this explanation depended on the availability of 70 percent actuarial value plans for these enrollees. We encourage the Secretary to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and the Secretary should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

NETWORK ADEQUACY

We oppose any proposal that erodes critical network adequacy standards and that would jeopardize access to providers with the appropriate experience and expertise to treat people living with HIV and hepatitis C. While we support efficient and non-duplicative monitoring and enforcement of insurance standards between state and federal regulators, we do not support using accreditation as a substitute for regulator enforcement. Because accreditation standards are not readily accessible, it will be impossible to determine adequate compliance with the ACA's network adequacy requirements with the only requirement being that plans have been accredited.

The proposal to defer network adequacy review to external accreditors is contrary to statute. The Secretary "shall, by regulation, establish criteria for the certification of health plans" to "ensure a sufficient choice of providers." (42 U.S.C. § 18031) These criteria must be subject to the full notice and comment requirements of the regulatory process. The proposed deferral to private standards, however, does not meet the requirements for criteria established by regulation, as the public is unable to review and comment on these private standards.

In states with robust network adequacy standards and review processes that are at least as protective as the ACA's federal standards and the National Association of Insurance Commissioners (NAIC) *Managed Care Plan Network Adequacy Model Act* (#74), we support deference to the state regulatory process. This must include quantitative time and distance standards. However, absent evidence of robust state monitoring and enforcement of network adequacy, HHS must step in to review plan justification of compliance with federal standards.

ESSENTIAL COMMUNITY PROVIDERS

We urge the Secretary not to finalize the proposed reduction in Essential Community Provider (ECP) network percentage to 20 percent. The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. This is particularly true for people living with HIV who depend on access to medical providers with HIV expertise who are primarily based at Ryan

White-funded clinics. Individuals with HIV whose care is managed by an experienced HIV medical provider are more likely to be virally suppressed and to receive more cost effective care

Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. Issuers have already developed these networks and must only maintain them. Issuers have developed and maintained these networks for the past three plan years, meaning that they are well-equipped to maintain these networks going forward. The justification for the proposed reduction – lessening the regulatory burden on issuers – is specious. Ninety-four percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen. Indeed, the proposed rule anticipates that this change will result in only \$1,155 in reduced disclosure burden in aggregate, nationwide – and affecting only 20 issuers. This is an insufficient justification to exclude 10 percent of the providers who see the most vulnerable beneficiaries.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs, particularly people living with HIV, have long-standing relationships with these providers and have built relationships that are a key component of successful management of HIV. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

Any treatment interruptions from a change in provider networks can substantially increase issuer costs. Among cancer patients, treatment interruptions increase total healthcare costs at a statistically significant level.² Similarly, people living with HIV who faced drug benefit design changes in Medicare Part D are six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality³ – similar outcomes may occur if Ryan White Program or other HIV ECPs are dropped from plan networks.

Because cost-savings under any reduction in ECP coverage are minimal, if not actually cost-increases, issuers' desire to reduce ECP coverage suggests an intent to discriminate against high-cost beneficiaries who predominantly use ECPs. Issuers have repeatedly discriminated against people living with HIV by discouraging enrollment through restrictive formularies,⁴ and excising Ryan White and other HIV ECPs

² Darkow, Theodore, et al. "Treatment interruptions and non-adherence with imatinib and associated healthcare costs." *Pharmacoeconomics* 25.6 (2007): 481-496.

³ Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." *AIDS and Behavior* 13.1 (2009): 1.

⁴ NASTAD. "Discriminatory Design: HIV Treatment in the Marketplace." July 2016. Available at: <https://www.nastad.org/sites/default/files/Discriminatory-Design-HIV-Treatment-in-the-Marketplace.pdf>. See also Florida Office of Insurance Regulation. "Consent Order: In the matter of: Coventry Health Care of Florida."

from plan networks would likewise discourage PLWH from enrolling. Because issuers have been successfully able to maintain 30 percent ECP networks for the past three plan years, any attempt to remove ECPs may be a proxy for removing the higher-cost beneficiaries who visit those ECPs. We strongly urge the Secretary to maintain the current 30 percent ECP network threshold and to carefully monitor plans that do eliminate ECPs for discriminatory benefit design.

We support maintenance of the existing 2017 write-in and narrative justification standards for ECP networks in 2018.

We urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, we are concerned that issuers will attempt to shed high-cost enrollees by eliminating their ECP from the provider network. Specifically, the Secretary should extend the continuity of care protections under 45 C.F.R. § 156.230(d) to provider discontinuations across plan years. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

Extending continuity of care provisions will have negligible impact on issuers because issuers must already follow these requirements for provider discontinuations within a plan year. A provider-issuer relationship will already be in place to facilitate provider reimbursement during the transition period. While we urge the Secretary to extend this protection to all consumers, regardless of provider, it is essential for those who see ECPs, particularly if the Secretary finalizes the ill-conceived reduced ECP network requirement.

COMPRESSED PUBLIC COMMENT PERIOD

Finally, we would like to express concern that the public comment period for this proposed rule was so compressed. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the significant proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Thank you, again, for the opportunity to comment on Market Stabilization Proposed Rule. We urge HHS to continue its commitment to ensuring that the ACA is implemented in ways that ensure that people

November 2014. Available at: <http://www.floir.com/siteDocuments/CoventryHCFL162231-14-CO.pdf>; "Consent Order: In the matter of: Cigna Health and Life Insurance Company." November 2014. Available at: <http://www.floir.com/siteDocuments/Cigna162232-14-CO.pdf>.

living with HIV and other chronic and complex conditions have access to quality, affordable health care coverage. Please contact Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org), Andrea Weddle with the HIV Medicine Association (aweddle@hivma.org), or Carmel Shachar with the Treatment Access Expansion Project (cshachar@law.harvard.edu) if we can be of assistance.

Respectfully submitted by:

Treatment Access Expansion Project | National Alliance of State and Territorial AIDS Directors | AIDS Action Baltimore | HIV Medicine Association | AIDS Action Committee of MA | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | The AIDS Institute | APLA Health | AIDS Treatment Data Network | AIDS United | American Academy of HIV Medicine | Association of Nurses in AIDS Care | Community Access National Network | Communities Advocating Emergency AIDS Relief (CAEAR) Coalition | Equality California | Gay Men's Health Crisis | Georgia AIDS Coalition | Harlem United | Health and Disability Advocates | HealthHIV | HIVictorious, Inc. | HIV Prevention Justice Alliance | Housing Works | Human Rights Campaign | Los Angeles LGBT Center | Moveable Feast | National Minority AIDS Council | The National Working Positive Coalition | National Viral Hepatitis Roundtable | Project Inform | San Francisco AIDS Foundation | South Carolina Campaign to End AIDS | Treatment Action Group | VillageCare